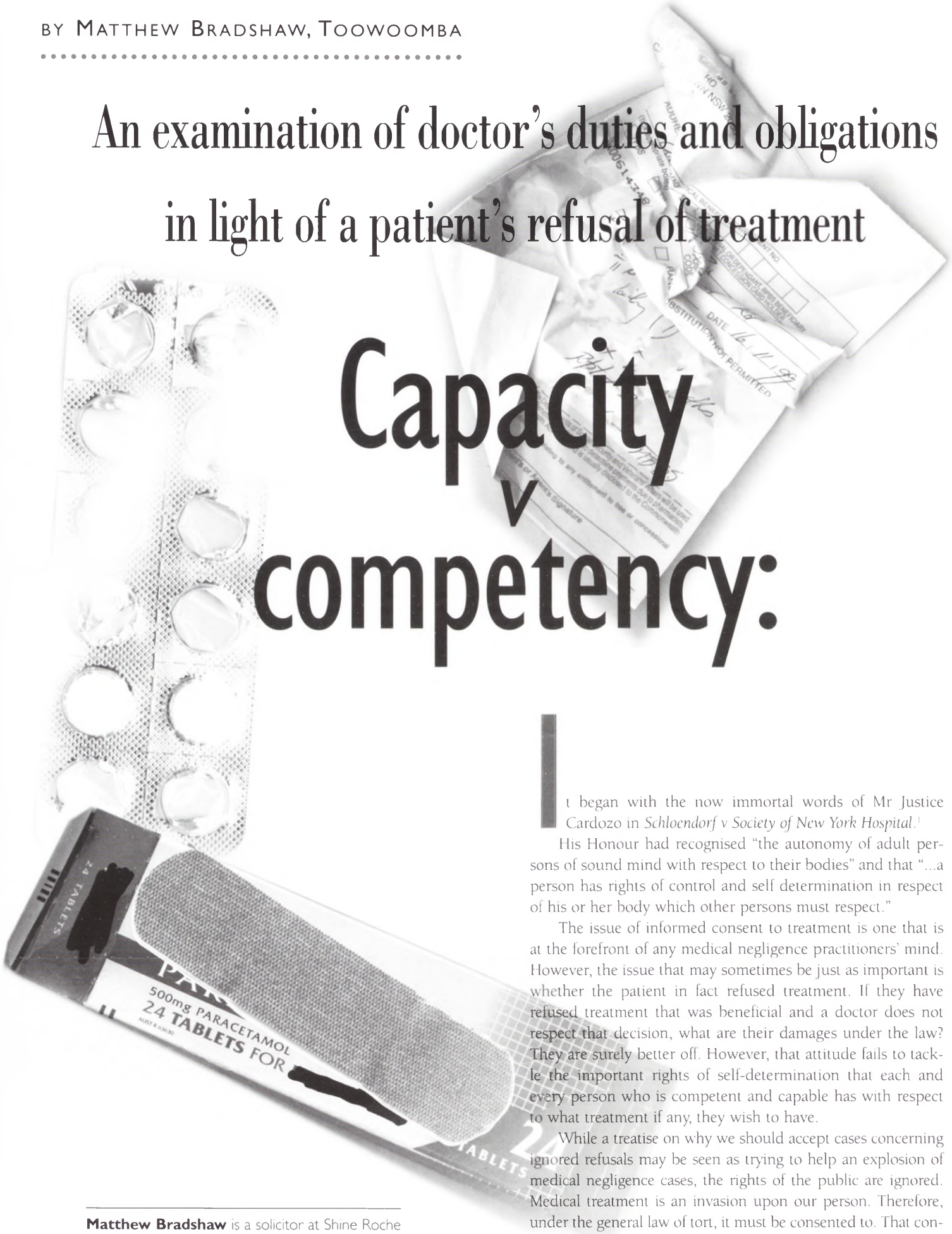
BY MATTHEW BRADSHAW, TOOWOOMBA

An examination of doctor's duties and obligations in light of a patient's refusal of treatment

Capacity v competency:



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It began with the now immortal words of Mr Justice Cardozo in *Schloendorf v Society of New York Hospital*.[1]

His Honour had recognised "the autonomy of adult persons of sound mind with respect to their bodies" and that "...a person has rights of control and self determination in respect of his or her body which other persons must respect."

The issue of informed consent to treatment is one that is at the forefront of any medical negligence practitioners' mind. However, the issue that may sometimes be just as important is whether the patient in fact refused treatment. If they have refused treatment that was beneficial and a doctor does not respect that decision, what are their damages under the law? They are surely better off. However, that attitude fails to tackle the important rights of self-determination that each and every person who is competent and capable has with respect to what treatment if any, they wish to have.

While a treatise on why we should accept cases concerning ignored refusals may be seen as trying to help an explosion of medical negligence cases, the rights of the public are ignored. Medical treatment is an invasion upon our person. Therefore, under the general law of tort, it must be consented to. That consent must be informed. However, if the consent is withheld, and the treatment is beneficial, unless the client is a Jehovah's Witness and the procedure is a transfusion, we tend to inform

the client that the case is not commercially viable to run. The fact that remains is that there is a prima facie case for the practitioner to answer. If the practitioner fails to respect a patient's refusal, perhaps, if the damages are limited under traditional heads due to a "benefit", then punitive damages may be appropriate.

There has never been a serious attempt within the common law world to erode the principal enunciated in *Schloendorf*. There have, however, been qualifications to the common law as a result of a lack of respect and or communication between medical staff and patients.

This discussion merely seeks to outline the issues that practitioners, patients and their advocates must consider when deciding whether the refusal of a patient is valid. No longer can we pigeonhole patients into categories of minors, mentally disabled and the like. We must take each case, examine the information given to the patient and then judge, given the subjective concerns of the patient, whether they were able to fully comprehend the issues and withhold consent. The test is different from that required to consent because the consequences are different. However, the rights of the patient in each case are the same.

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Refusal: the general principles

In Australia, there are no appellate decisions nor does it appear that there is a reported judgment dealing with either injunctive relief by a patient preventing medical staff from acting or declarative relief by medical staff that a course of action or its continuation is lawful.

In the United Kingdom, there are numerous decisions of applications brought by either the patient[2] or medical staff.[3]

Re C was an application brought by a 68 year old paranoid schizophrenic. C thought that he had been a great doctor and was institutionalised. His leg was infected and doctors argued that the only way to save his life was to amputate. C brought an application to prevent the amputation without his express consent. The Court granted his application.

In the other corner, is *B v Croydon*, where a hospital was granted a declaration that they were not acting unlawfully in forcibly providing B with naso-gastric nutrition. B, who suffered from Anorexia Nervosa, argued that while her consent was not required under the UK *Mental Health Act* 1983 to treat her psychiatric condition, consent was required for treating any other condition. Her argument was that providing nutrition was not treating the cause of the illness, but rather the symptoms and therefore required her consent, which she was entitled to withhold. The court held that a holistic approach to the condition was required and allowed the hospital to treat the illness and symptoms as required to sustain life.

However it is of note that despite these applications, there has been no departure from the principal that every person of full age and capacity has the right of self-determination including the right to refuse medical advice and treatment. In fact, one may argue that practitioners are now more restricted as children and even patients regulated under Mental Health Legislation obtain more rights of determination.[4]

The lack of applications in Australia similar to those brought by B,[5] S,[6] T[7] and C[8] is interesting. To ponder a reason may be to inquire of bodies such as the Adult Guardian to find out whether such decisions are receiving the consent of these bodies. Perhaps, as Loane Skene[9] suggests, medical practitioners are ignoring (or are ignorant of) legislation and common law. This could result in practitioners wrongly overturning refusals, or simply failing to obtain valid consents.

Either way it is clear that many patients are either unable to enforce their rights as B did or are unaware of their right of refusal. It would also not be too outrageous to suggest that unlike Mr Fazlic[10] many patients will trust their doctor so implicitly that their consent, whilst obtained, does not satisfy the principles of "informed consent".

In *Fazlic*, the plaintiff suffered a back injury that required a relatively major operation to rectify. There was no guarantee that at the completion of the operation, the plaintiff would be any better off. Without it, there was no chance of a recovery. The plaintiff decided that he would not undergo the operation on the grounds, inter alia, that he had a fear of operations and that he may be worse after the operation. The surgeon respected that decision and did not operate. However, the employer contended that the plaintiff had unreasonably refused to mitigate his damage and therefore his damages should be reduced for this failure. The court held that his refusal was not unreasonable in light of the information given to him concerning the risks and consequences of the surgery.

This case perhaps illuminates the point that where there is poor communication between doctors and patients with respect to the expectations of each party, it is the misunderstanding of what a successful outcome is for each party and conversely, what an adverse outcome is, that may lead in many cases, to complaints and litigation.

Indeed, based on the lack of applications in Australia,[11] I would suggest that many patients' refusals are being overturned or ignored, mainly because medical practitioners make a decision that the refusal is either unreasonable or invalid because the patient has made their decision without having material risks and outcomes explained to them.

Qualifications to the Common Law Rule

A refusal to undergo treatment will be legally enforceable and sound in damages.[12] However, there are situations when a refusal will not be able to be enforced nor sound in damages. Skene outlines these as potential defences for overriding the refusal of competent patients. She suggests that the only situations which would override a refusal are:-

1. to assess a patient as being incompetent; or
2. when the refusal does not cover the situation which has in fact occurred.[13]

The Assessment of Competency

The first qualification is perhaps avoidance of the rule rather than a qualification of it. However, practically, if a medical prac- ▶

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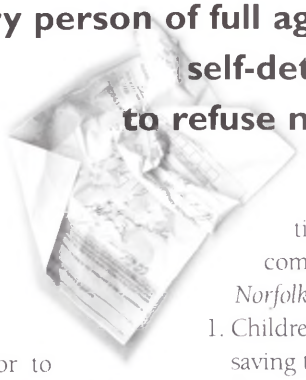

titioner assesses a patient as not competent to refuse treatment, they may ignore the refusals. It should not, however, act as a positive form of consent. In this instance, either a Court Order approving the treatment, or the consent of an appropriate legislative body such as the Legal or Adult Guardian would be required to protect the doctor performing the treatment.

Skene[14] suggests that "[i]t is for the doctor to determine competence in each case". But which doctor? It is, in my opinion, a decision that either cannot or should not be made by any practitioner with an interest in a resulting treatment. That is, an independent practitioner, namely a Psychologist or Psychiatrist, after an assessment or file review (in the case of an emergency) should be the only qualified persons to overturn a refusal by a patient. In no situation should it be contemplated that the treating doctor should be the only assessing physician to make the decision. It is of course a conflict of interest and one that will impact in no small way upon the professional reputation of the practitioner and the profession as a whole.

The question of competency depends on the circumstances in which it must exist. A patient who is not fully orientated in relation to some issue may be competent to give or withhold consent with regards to other issues.

In *Re C*,[15] C, a paranoid schizophrenic with delusions of being a doctor was found to be competent to refuse the amputation of his leg. Thorpe J granted C an injunction to prevent the hospital amputating his leg without his express consent. The hospital's experts argued that the failure to amputate would result in the patient's death. It is important to note that simply because a patient is regulated pursuant to Mental Health Legislation does not automatically entitle a practitioner to disregard their right to refuse treatment.

However in *Re S* (Adult: Refusal of Treatment)[16] Sir Stephen Brown P granted a declaration for the medical practitioners overturning the refusal of an adult female in labour. Labour had commenced spontaneously and had not progressed for two days. The baby's elbow was projecting through the cervix and a caesarean section was decided to be the only option that would save the lives of both the mother and child. It was accepted that if no action was taken, then both the mother and the child would die.[17] The ground of refusal was that S was a "born again Christian" and the operation violated her religious beliefs. The reasons for judgment were not detailed as the Judge delivered his judgment a mere 48 minutes after the application was filed in the Registry and after only 30 minutes of legal argument. In this case, the official solicitor appeared Amicus Curiae to represent the rights of the patient.

Brown P acknowledged that there was no English authority on point but that in *Re AC*,[18] a Californian decision did suggest authority for him to grant the declaration.

The important principle from *Re S* is not so much the reasons for Brown P's decision, but rather that the Court would grant an application seeking to overturn the refusal of the patient with no history of mental illness. Competency to consent to or refuse medical treatment does not necessarily depend on the existence of a legal disability or the question of capacity.[19] As regards minors, the issue of competency was discussed in the matter of *Gillick v West Norfolk*.[20] This case suggested that:

1. Children can, if competent, refuse treatment including life saving treatment; and
2. Their age is not determinative of their competency.

There is also a suggestion in *Gillick* that competency does allow a consent, but that a refusal to treatment can still be overturned by the consent of a parent or guardian.[21]

Where the Refusal does not cover the situation

The refusal is only as good as the ability of the patient to weigh the risks. If the situation outlined to the patient is not the situation the doctor finds themselves in, that refusal may be able to be ignored. In *Re T*[22] the Court held that capacity to refuse was impaired because medical staff did not adequately warn T of the risks of the procedure. She was told that the procedure was routine and that it was unlikely that anything would go wrong. When the emergency subsequently took place, it was a sufficiently different scenario which enabled the refusal of blood to be ignored and for a transfusion to be given. T's mother, a practising Jehovah's Witness, was also held to unduly influence T's decision. However, the main issue was one of whether the refusal covered the situation the doctors found themselves in. It did not.

This may lead to artificial refusals by patients. If a practitioner decides to withhold vital information from a patient, they could later ignore a refusal by a patient where a foreseeable event occurs but was not disclosed to the patient thereby creating a situation outside the refusal. In Australia, this is not so much of an issue as there is already a duty placed on the doctors and other medical staff to inform a patient of all material risks involved with the procedure.[23] However, this duty does not extend to emergency situations. In order to prevent patients' rights being ignored, the manufacture of an emergency by a medical practitioner through not informing the patient of the risks of the procedure, should still sound in damages. This is because it is the failure of the doctor to adequately inform a patient of their right and the risks that they are about to undertake that results in the injury to the client. That injury in this case, may simply be the pain and emotional trauma of not having their rights and refusal respected.[24]

The test for competency therefore under the English authorities, is that the patient must understand the "nature, purpose and effects of the proposed [treatment]".[25]

In *B v Croydon Health Authority*[26] the Court of Appeal held that despite B's competency, because she was regulated and the treatment related to the mental illness, namely anorexia nervosa, she was not required to give consent for naso-gastric feeding. The decision was based upon the English *Mental Health Act* 1983 which specifically removed the need for consent when treating a regulated patient for the mental illness itself. During the case the issue of whether forced naso-gastric feeding was treatment for the mental illness or for the symptoms arising as

a result of the underlying illness were discussed in detail. In the end, the decision was that the illness must be looked at and treated as a whole and that the forced provision of nutrition was treatment which did not require the consent of the patient. This is an example therefore of legislative removal of a competent patient's right of refusal.

In comparison, in *Secretary of State for the Home Department v Robb (Robb's Case)*,[27] Thorpe J again respected the right of refusal of a patient on a hunger strike. Mr Robb was a prisoner diagnosed with a personality disorder who had a propensity for hunger strikes. The prison authorities requested a declaration that they might:

1. Lawfully observe and abide by the respondent's (Robb) refusal to receive nutrition; and
2. Lawfully abstain from providing him with hydration and nutrition whether by artificial means or otherwise for so long as he retained the capacity to refuse the same.[28]

The medical experts agreed that he was of sound mind and also that he was able to judge the consequences of his actions.

In the absence of clear authority, Thorpe J in *Robb's Case* delivered a judgment outlining four guiding principles:

1. Every person's body is inviolate and proof against any form of physical molestation;[29]
2. The principle of self determination requires that respect must be given to the wishes of the patient;[30]
3. A patient who is entitled to consent to treatment which might or would have the effect of prolonging his life and who refuses so to consent, and by reason of the refusals subsequently dies, does not commit suicide;[31]
4. The presumption of capacity in an adult may be rebutted.[32] The definition of capacity is the three fold test adopted in *Re C*.

What we see is an absence of authority in Australia. In that absence of authority it is my opinion that we see assumptions being made resulting in ad hoc decisions and poor communication with patients. Perhaps the most important issue to take from this discussion is that there is a lack of documentation surrounding many issues of treatment concerning informed consent or refusal by a patient. It is not simply a matter of educating the medical professions, rather, it is the development of policies and clear guidelines on documentation of the informed consent or refusal. It is also the guidelines surrounding who has the right to determine competency and capacity of a patient.

To support the words of Mr Justice Cardozo above, I conclude with the words of C; "I would rather die with two feet than live with one". That was his right and who are we to decide he was unable to make that decision. PL

Footnotes:

1 (1914) 105 NE 92,93
2 In *Re C* (Adult refusal of medical treatment) [1994] 1WLR290 (*Re C*)
3 *B v Croydon Health Authority* [1995] 2WLR294 (B v Croydon)
4 See *Gillick v West Norfolk & Wisbech Area Health Authority* [1985] 3 All ER 402 (*Gillick v West Norfolk*) and *Re C* (Supra)
5 *B v Croydon* (supra)
6 In *Re S* (Adult: Refusal of Treatment) [1992] 3 WLR 806 (*Re S*)
7 In *Re T* (Adult: Refusal of Treatment) [1992] 3 WLR 782 (*Re T*)
8 *Re C* (supra)
9 "When can doctors treat patients who cannot or will not consent" (1997) 23 *MonLR* 77
10 *Fazlic v Milingimbi Community Inc* (1982) 150 CLR 345
11 such as those in *Re T*, *Re C* and *B v Croydon* (supra)
12 *Malette v Schulman* (1990) 67 DLR (4th) 321
13 Skene, [1997] 23 Mon LR 77,84
14 ibid.
15 [1994] 1 WLR 290
16 [1992] 3WLR 806
17 [1992] 3WLR 806, 807
18 [1990] 573 .2D1235
19 *Gillick v West Norfolk* (supra)
20 *Gillick v West Norfolk* (supra)
21 For a discussion of this point see "White Coats or Flack Jackets? Doctors, Children and the Courts - Again" [1993] 109 LQR 182
22 supra
23 *Rogers v Whitaker* (1992) 175 CLR 479
24 *Malette v Schulman* (supra)
25 *Re C* [1994] 2 WLR 292, 295
26 supra
27 [1995] 1 ALL ER 677
28 [1995] 1 ALL ER 677 at 677
29 *F v West Burkeshire Health Authority* [1990] 2 AC 1
30 *Re T* (supra)
31 *Airdale NHS Trust v Bland* [1993] AC 789
32 *Re T* [1992] 4 ALL ER 649, 661-2